DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

6150
Ser M3/5 HCS3/AT-57506
23 Feb 10

MEMORANDUM FOR COMMANDER, NAVY MEDICINE EAST
COMMANDER, NAVY MEDICINE WEST
COMMANDER, NAVY MEDICINE NATIONAL CAPITAL AREA
COMMANDER, NAVY MEDICINE SUPPORT COMMAND

Subj: CODING PROGRAM STANDARD AUDIT GUIDELINES

Ref: (a) DoD Instruction 6040.40, "Military Health System Data Quality Management Control Procedures," November 26, 2002
(b) DoD Instruction 6040.42, "Medical Encounter and Coding at Military Treatment Facilities," April 13, 2004
(c) BUMEDINST 6150.38
(d) NAVMED Policy 09-019, Military Health System (MHS) Guidelines for Inpatient Coding
(e) CNO memo 5200 Ser 82/09UM821129 of 19 Jun 09

Encl: (1) Navy Medicine Standard Coding Audit Requirements and Guidelines – February 2010

1. Accurate and effective coding of medical records is a cornerstone of patient and family centered care. Accordingly, Navy Medicine must take whatever steps are required to ensure that providers and coding staff, as a team, are meeting all requirements. This memorandum provides supplemental policy and guidance to references (a) through (d) and addresses material deficiencies noted in reference (e). Enclosure (1) implements guidelines for conducting audits and standardizing medical record review processes to improve documentation of patient encounters and coding. These guidelines supplement internal management control processes and support the Data Quality Management Control (DQMC) program for coding accuracy.

2. Navy Medicine Regional Commanders and Medical Treatment Facility (MTF) Commanders/Commanding Officers are directed to implement the requirements and guidelines as outlined in enclosure (1). MTF Commanders/Commanding Officers, Head, Patient Administration Departments, and Head, Financial Management Departments are expected to comply with the requirements outlined in the guide and routinely evaluate the alignment of their efforts with the requirements included in the guide. They are to ensure that all clinical documentation, clinical coding, and administrative procedures surrounding patient encounters are conducted following the requirements of this guidance, applicable State and Federal laws, and The Joint Commission. Navy MTF and Clinic compliance with the standard coding and audit requirements and guidelines will be reviewed during Navy Medicine Inspector General visits.

3. My points of contact are Lieutenant Commander H. Teamer, MSC, USN, at (202) 762-3126 or Hazelann.Teamer@med.navy.mil or Ms. S. McConnell-Lamptey at (202) 762-3166 or Shannon.McConnell-Lamptey@med.navy.mil.

4. Forms and Reports

a. The following NAVMED forms are available electronically from Naval Forms Online at https://navalforms.daps.dla.mil/web/public/home:

(1) NAVMED 6150/44 (01-2010), Inpatient Coding Audit Worksheet
(2) NAVMED 6150/45 (01-2010), Outpatient Clinic Visit Coding Audit Worksheet
(3) NAVMED 6150/46 (01-2010), APV Coding Audit Worksheet
(4) NAVMED 6150/47 (01-2010), IPS RNDS Coding Audit Worksheet
(5) NAVMED 6150/48 (01-2010), Inpatient Coding Audit Summary
(6) NAVMED 6150/49 (01-2010), IPS RNDS Coding Audit Summary
(7) NAVMED 6150/50 (01-2010), Outpatient Coding Audit Summary
(8) NAVMED 6150/51 (01-2010), APV Coding Audit Summary

b. The reports required by this memorandum are assigned report control symbol NAVMED 6150-2. This reporting requirement is approved by Chief, Bureau of Medicine and Surgery for 3 years from the date of this memorandum.

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NAVY MEDICINE STANDARD CODING AUDIT REQUIREMENTS AND GUIDELINES

February 2010

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1 Purpose of Document

Bureau of Medicine and Surgery (BUMED) has embarked on several policy initiatives to standardize the medical coding function at Navy Medical Treatment Facilities (MTFs) in order to reduce variations, increase consistency, and improve coding accuracy. Improving coding operations and addressing concerns for standard auditing requirements/guidelines is the goal of this policy document. The lack of standard auditing requirements and guidelines has lead to inconsistent and incomplete coding analysis that could result in misrepresenting coding accuracy to the MTF leadership, Navy Medicine, Assistant Secretary of Defense (Health Affairs) (ASD(HA)) and Congress.

Coded data is used by the Military Health System (MHS) for many organizational healthcare business decisions, necessitating policy development and standardization in this area. The auditing processes in this document will address coding accuracy, timeliness, and completeness, and provide a standard methodology for sampling, reporting, and calculations—yielding more consistent data analysis. This will aid leadership in identifying corrective actions that must be taken to improve Navy performance, capture workload and revenue, and improve clinical documentation. This, in turn, helps promote readiness throughout the Navy.

1.1 Why Audit?

The use of medical coded data for decisions continues to grow and numerous decisions are being based upon clinically coded data. As such, the timeliness, completeness, and accuracy of this data become critically important. Therefore, the number of errors that are due to the lack of complete clinical documentation, transcription errors, and/or judgment errors should be minimized. Audits are a common method used in the civilian sector to monitor, understand, and address coding errors and operational and/or systems issues impacting productivity, third party collections, budget allocations, personnel requirements, healthcare measures, etc. These same issues are important for the MHS as well.

Audits conducted will compare what is clinically documented in the medical record to what was coded. Audits must be viewed as a compliance and communication vehicle for both providers and coders. As such, MTF audits should be treated as an important educational tool to evaluate policies, business practices and processes, and to help identify training opportunities for personnel. Audits that focus on coding corrections alone will not fundamentally allow for improvement in Navy clinically coded data, productivity, and/or financial posture within the MHS.

1.2 What Does it Offer Command Leadership?

Auditing has an important role in the resourcing of future operations as well as in the monitoring for high quality and acceptable standards of care. An active audit program reinforces the MTF's ability to produce accurate and complete medical coding data sets from clinical documentation recorded in individual patient medical records. Accurate and complete medical coding data sets directly impact an MTF's quality measures that are reported by existing Healthcare Effectiveness

Data and Information Set (HEDIS) performance metrics and future Prospective Payment System (PPS) earnings.

2 Overview of Medical Coding Audit Requirements and Guidelines

These *Navy Medicine Standard Coding Audit Requirements and Guidelines* provide guidance for conducting coding audits and medical record reviews. Coding audits are conducted to determine whether the medical record documentation reasonably supports the diagnostic and procedural codes assigned. Coding audits are currently required by two separate Department of Defense Instructions (DoDIs) to determine coding accuracy, completeness, and timeliness. Those two DoDIs are:

(a) DoD Instruction 6040.40, "Military Health System Data Quality Management Control Procedures," November 26, 2002

(b) DoD Instruction 6040.42, "Medical Encounter and Coding at Military Treatment Facilities," April 13, 2004

These DoD-mandated audits offer visibility into departmental operations and coding processes. After completion of the audits, feedback meetings are necessary to review the findings and discuss corrective actions to improve coding and documentation based on any issues identified. If coding shows improvement from one quarter to the next, the facility can be relatively confident it is getting the most from its audits.

2.1 Audit Reference Materials

Navy Medicine MTFs will conduct monthly documentation and coding audits for inpatient, outpatient, Ambulatory Procedure Visit (APV), and Inpatient Professional Service (IPS) records to determine coding accuracy.

(a) The coder/auditor shall follow the coding guidelines established by the MHS as follows:

- Facility Services Coding: *Military Health System Inpatient Coding Guidelines*
- Professional Services Coding: *Military Health System Professional Services and Specialty Coding Guidelines*

(b) Supplemental Auditing Guidelines. If there are no guidelines specific to the MHS outlined in the references in Section 2, the coder/auditor shall refer to the following publications as definitive references:

- International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) Official Coding Guidelines
- *Principles of Current Procedural Terminology (CPT) Coding*, American Medical Association

- *Coding Clinic for ICD-9-CM*, American Hospital Association
- *Coding Clinic for Healthcare Common Procedure Coding System (HCPCS)*, American Hospital Association
- *CPT Assistant*, American Medical Association
- *CPT*, Fourth Edition – Edition in effect for Dates of Service being audited
- Medical Dictionary
- Healthcare Common Procedure Coding System (HCPCS)
- Coding Compliance Editor (CCE) Coding Reference Library

2.2 What Comprises a Complete Medical Record for Audit Purposes?

Medical record audits must include review of the entire inpatient admission (from admission to discharge) for inpatient chart audits. For APV records, the medical record must include all the documents related to that encounter/episode of care. Audits for outpatient visits must include review of all applicable components of the encounter. Audits will be done on completed records only.

(a) At a minimum, inpatient records shall include the following documentation where applicable:

- Summary sheet documenting the codes selected by the MTF personnel
- Discharge Summary
- Anesthesia Record
- History and Physical Exam
- Physician Orders
- Operative Reports
- Reports for any special procedures such as Electrocardiogram (EKG), Magnetic Resonance Imaging (MRI), where applicable
- Consultation Reports
- Admission Note/ History & Physical (H&P)
- Progress notes from physician, nurse practitioner, physician assistant or other specialty provider
- Laboratory Reports
- Pathology Reports, where applicable
- Medication Records
- Nurses Notes
- Ancillary Reports
- * Emergency Department documentation
- * Outpatient visit documentation

* Also included when these encounters resulted in an admission. Ambulance records or copies of any records from transferring facilities would be included.

(b) At a minimum, APV records shall include the following documentation where applicable:

- Summary sheet documenting the codes selected by the MTF personnel

- Discharge Summary
- Anesthesia Record
- History and Physical Exam
- Physician Orders
- Operative Reports
- Admission Note
- Progress notes from physician, nurse practitioner, physician assistant or other specialty provider
- Nurses Notes
- Ancillary Reports
- Laboratory Reports
- Pathology Reports, where applicable
- Medication Records
- * Emergency Department documentation
- * Outpatient visit documentation

* Also included when these encounters resulted in an admission. Ambulance records or copies of any records from transferring facilities would be included.

(c) At a minimum, outpatient records shall include the following for the date of services requested where applicable:

- Providers notes
- Nurses notes
- Reports of any special procedures such as EKG, MRI, where applicable
- Laboratory Reports, where applicable
- Pathology Reports, where applicable

2.3 Types of Audits

The following types of audits when, conducted by the coder/auditor for inpatient, outpatient, APV and Inpatient Professional Services; shall be conducted per these audit guidelines:

(a) Random Audits. Random audits are required by the references indicated in Section 2(a) and 2(b). These audits are considered spot checks of overall data. The Data Quality Management Control (DQMC) requires that monthly random audits be conducted for inpatient, outpatient, and APV encounters (see section 2.4). In addition to spot-checking overall data, these random audits are performed at least once each fiscal year by the MTF to assess new providers who have just completed their professional training (i.e., residency, fellowship, or Nurse Practitioner training). These random audits are also performed at least once each fiscal year by the MTF on new coders.

(b) Audits of Providers. For the purpose of this audit, providers are defined as clinicians with designations of Skill Type 1 or Skill Type 2. Skill Type 1 is defined in the *Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment*

Facilities (2000) as "clinicians to include physicians, dentists, and veterinarians." Skill Type 2 is defined in *MEPRS* as "direct care professionals, non-physicians, that are licensed or certified to deliver care to patients and include, but not limited to, physician assistants, nurse practitioners, physical and occupational therapists, psychologists, and nurse midwives."

The auditing requirements for these providers are as follows:

- Providers who are just completing training (i.e., residency, fellowship) will be audited within 30-60 days of the start of their assignments.
- Providers who are new to the MTF will be audited within 30-60 days of the start of their assignments.
- If the provider accuracy is below 90%, the coding supervisor or designee will provide educational feedback in the area of deficiency with a follow up review of problem areas within 15-30 days.
- The audit will include a minimum of 10 records/encounters with a range of Evaluation and Management (E/M) categories and levels as well as procedures reported. If the provider provides more than one type of service (professional clinic, professional APV procedure visit, or inpatient facility rounds), 10 records from each type of service is required.
- If the coder/auditor finds a contract provider's accuracy is below 90%, the coder's supervisor should provide sufficient information through the MTF chain of command to the appropriate Patient Administration Department (PAD)/Contracting Officer's Representative (COR) designee so the contractor can be formally notified of the deficiency.
- If the provider is privileged and works in more than one specialty, an audit for each specialty is required.

(c) Audits of Coders. For the purpose of this audit, coders are defined as military, civilian, and contract coding personnel. The auditing requirements for coders are as follows:

- Coders new to the MTF will be audited within 30-60 days of the start of their assignments.
- If the coder accuracy is below 95%, the coding supervisor or designee will provide educational feedback in the area of deficiency with a follow up review of problem areas within 15-30 days.
- The audit will include a minimum of 10 records/encounters from each area of responsibility with a range of E/M categories and levels, a range of Diagnosis Related Groups and procedures reported, and APV categories. If the coder codes for more than one type of service (professional clinic, professional APV procedure visit, or inpatient facility), an audit for each type of service is required.
- If the coder/auditor finds a contract coder's accuracy is below 95%, the coder's supervisor should provide sufficient information to the COR so the contractor can be formally notified of the deficiency.

2.3.1 Calculations and Formulas

Calculations and formulas (and some practical examples on how to apply them in specific audit situations) are supplied in order to develop uniformity and consistency in audit data. (For example, when calculating *CPT* accuracy, some MTFs audit only the first-listed *CPT* for an encounter, while other MTFs review all the *CPT* codes assigned to an encounter. Having a clear set of calculations and formulas will make it easier to compare data between MTFs.)

Calculations and Formulas are provided to determine the accuracy of one individual chart in an audit sample. "Roll-up" Calculations and Formulas are also provided to aggregate the accuracy figures when reporting the collective cross-sample level of accuracy for a particular audited element.

Because past reporting has indicated both overreporting and underreporting of services, standard audit calculations need to quantify any overcoding errors and undercoding errors.

Accuracy calculations shall use a denominator that is the *sum* of the number of codes that were reported originally by the coder *plus* the number of codes that were found to be missing by the coder/auditor. For example:

> *Thirty charts were audited. Of the 75 CPT codes originally reported, 70 were found to be correctly linked to all appropriate ICD-9-CM codes. Eight additional CPT codes were found to be missing by the coder/auditor. Seventy is divided by the combined total of 75 original CPT codes plus the eight additional CPT codes that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.*

2.4 Targeted Audits

Targeted audits are usually triggered by an actual or perceived problem area or to monitor compliance with new coding guidance or standards. These audits identify individual or focused training needs such as The Joint Commission ORYX measures, present on admission indicators, "high volume" and "high relative value unit (RVU)" records. A minimum of one targeted audit shall be performed at each MTF annually.

2.4.1 Elements of Targeted Audits

Below are some recommended data elements for a targeted audit. A random audit may identify that there is a problem, but a targeted audit provides greater audit granularity to identify the scope or specific root cause of the problem. Because targeted audits are based on issues identified by the MTF as needing assessment or quantification, the number of records needed to investigate the issues will be highly variable. It is therefore left to the discretion of the MTF to determine a statistically valid sample size and audit sample timeframes for targeted audits and to

obtain a sample size during a timeframe that delivers a comfort level that any identified issues of concern are indeed being adequately measured.

2.5 Sample Size, Frequency, and Timeframes of DQMC Audits

Per the DQMC requirements as outlined in DoD Instruction 6040.42, "Medical Encounter and Coding at Military Treatment Facilities," a minimum of 30 records will be selected for each type of monthly required coding category. The MTF Region and BUMED may require larger sample sizes, as deemed necessary. The following sections provide detail regarding sample size, frequency and sampling timeframes. For more specific information refer to annual DQMC guidance.

2.5.1 Random Audit Sample Size: Inpatient Audits

The minimum sample size will be 30 randomly selected records. A greater sample size might be deemed necessary by the command. If dispositions are fewer than 30 for an audit month, all inpatient records will be audited.

2.5.2 Random Audit Sample Size: Outpatient Audits

The minimum sample size will be 30 random records. A greater sample size might be deemed necessary by the command. If the 30 selected records are unavailable by the time auditing work must begin, records can continue to be randomly sampled until at least 30 records are available for review.

2.5.3 Random Audit Sample Size: APV Audits

The minimum sample size will be 30 random records. A greater sample size might be deemed necessary by the command. If the 30 selected records are unavailable by the time auditing work must begin, records can continue to be randomly sampled until at least 30 records are available for review. Additionally, if fewer than 30 APVs were performed in any month, then all APVs should be audited.

2.5.4 Random Audit Sample Size: Inpatient Professional Services Audits

The records audited will be based upon the inpatient records selected. See DoD Instruction 6040.42, "Medical Encounter and Coding at Military Treatment Facilities," April 13, 2004 for complete instructions on how to determine which days within the inpatient period of care should be audited.

2.5.5 Random Audit Frequency

Per the DQMC requirements as outlined in DoD Instruction 6040.42, "Medical Encounter and Coding at Military Treatment Facilities," random audits must be accomplished on a monthly basis based upon the entire population of records/encounters for the audit data month.

2.5.6 Random Audit Timeframe

Random audits shall be conducted no earlier than 45 days after the close of the encounter date/month. This ensures the medical records are complete with proper signatures and clinical documentation.

2.6 Who can Audit?

When determining who should perform the audit, consideration must be given to the focus of the audit. The coder/auditor should have knowledge of the MHS Coding Guidance and at least six months' coding experience with the types of services that are to be audited. For example, you would not want a coder who has five years of experience coding ob-gyn services to review orthopedic services. The coder/auditor is required to have the following appropriate credentials for conducting the review:

(a) Inpatient or outpatient facility coding: Certified Coding Specialist (CCS), Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT).

(b) Inpatient or outpatient professional services coding, including APVs: RHIA, RHIT, Certified Coding Specialist (CCS), Certified Coding Specialist-Professional (CCS-P), Certified Professional Coder (CPC), Certified Professional Coder-Hospital (CPC-H).

(c) The coder/auditor performing the review will not have coded any of the records/encounters being reviewed. This may require retaining the services of an outside coder/auditor, or the MTF can contact the Navy Medicine Region Commander to make arrangements to have another MTF assist as a coding/auditing resource.

The coder/auditor will need to complete the pertinent care setting coding Audit Scoresheet Tool for each inpatient episode of care or outpatient encounter audited. The Audit Scoresheet Tools recommended for use are:

- Evaluation and Management Services Worksheet: CMS 1995 or 1997 *Documentation Guidelines for Evaluation and Management Services* (depending upon the Outpatient Coding Protocol Plan) (available at Sections 4.5 and 4.6 of this document)
- NAVMED 6150/46, APV Coding Audit Worksheet
- NAVMED 6150/44, Inpatient Coding Audit Worksheet (Please Note: As of 1 October, 2008, the MHS utilizes the Medicare Severity-Diagnosis Related Groups.)
- NAVMED 6150/45, Outpatient Clinic Visit Coding Audit Worksheet
- NAVMED 6150/47, Inpatient Professional Services (IPS) Rounds Coding Audit Worksheet

Facilities must indicate in their Outpatient Coding Protocol Plan which set of Centers for Medicare and Medicare Services (CMS) guidelines each clinical service will follow. The coder/auditor will audit using the same set of CMS coding guidelines required by the MTF's Outpatient Coding Protocol Plan. The coder/auditor will need to complete the following calculations and comment fields for each audit worksheet.

(a) RVU/Relative Weighted Product (RWP) Difference: Calculation of the difference between Audited RVU/RWP and Original RVU/RWP from the CCE.

(b) Physician Query: If the coder/auditor identifies that a query should have been made, he/she will note such in the physician query area of the audit sheet. If available, the CCE Review Hold report must be used to identify if comments were made and the reason they are on "review hold" status.

(c) Coder/Auditor Comments: The coder/auditor shall provide written comments regarding any disagreements between original and audited codes. The comments will be clear concise statements.

(d) Error Reason Codes Definitions: The coder/auditor shall assign the appropriate "Error Reason Code" to identify the type of discrepancy between the original codes and the audited codes. The table of Error Reason Codes can be found in Section 7.

2.7 Retrospective Physician Query Process

The American Health Information Management Association (AHIMA)'s document *Standards for Ethical Coding* indicates:

> "Query provider (physician or other qualified healthcare practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g., present on admission indicator)."

In light of new official coding rules that have been implemented regarding discrimination between conditions that are present at the time of admission and conditions acquired during the admission, coders need to clarify information with providers. This, in turn, means that the coder/auditor might need to make these very same types of queries during the retrospective audit if important information was left illegible, incomplete, unclear, inconsistent, or imprecise when the chart was coded originally.

Since reimbursement can be driven by how precise diagnostic information is, an opportunity exists to make sure MTFs are making good use of a physician querying process and are asking the necessary questions to optimize diagnostic data capture. An important part of the audit process is to review the entire inpatient encounter, from the History and Physical document to the Discharge Summary and everything in between. Query the physician retrospectively as part of the audit process to determine if the initial coding had been optimized at the outset.

2.8 Steps to Performing a Querying Process Audit

(a) Certain high-risk primary or secondary procedures and diagnoses have the potential to change an MS-DRG through retrospectively querying the physician. The coder/auditor may identify areas where source data is insufficient and a retrospective query needs to be initiated. This could yield opportunities to provide increased education to providers and coders on the high-risk procedures and diagnoses.

> *Example: Thirty charts were audited and three retrospective query opportunities were identified. Dividing the number of query opportunities (3) by the combined total of 30 original charts plus zero additional charts that were found by the coder/auditor but which were missed by the original coder (30 + 0 = 30). 3 divided by 30 equals 10.0% query rate.*

(b) Similarly, certain procedures from a *CPT* standpoint are high-risk for providing inaccurate workload data. Whether a surgical procedure was done "open" or laparascopically, whether a procedure was an initial procedure or a subsequent procedure, whether a procedure was simple or complicated—all can affect the *CPT* code selection. A review should seek to confirm if coders are properly using query forms to clarify proper code selection.

(c) Audit individual providers to confirm clarity and thoroughness of chart documentation. Improvement in documentation should result in a decreased number of queries for an individual provider.

(d) The querying process could be misused or overused. The coder/auditor may identify areas where retrospective querying was unnecessary. Unnecessary querying might include questioning a provider's clinical judgment.

Querying a provider shall be limited to situations regarding:

- **Legibility.** This might include an illegible handwritten entry in the provider's progress notes, and the reader cannot determine the provider's assessment on the date of discharge.

- **Completeness.** This might include a report indicating abnormal test results without notation of the clinical significance of these results (e.g., an x-ray shows a compression fracture of lumbar vertebrae in a patient with osteoporosis and no evidence of injury).

- **Clarity.** This might include patient diagnosis noted without statement of a cause or suspected cause (e.g., the patient is admitted with abdominal pain, fever, and chest pain and no underlying cause or suspected cause is documented).

- **Consistency.** This might include a disagreement between two or more treating providers with respect to a diagnosis. (For example, the patient presents with shortness of breath. The pulmonologist documents pneumonia as the cause and the attending documents congestive heart failure as the cause.)
- **Precision.** This might include an instance where clinical reports and clinical condition suggest a more specific diagnosis than is documented (e.g., congestive heart failure is documented when an echocardiogram and the patient's documented clinical condition on admission suggest acute or chronic diastolic congestive heart failure)

Example: Thirty physician query forms were audited for negative and positive provider responses. A high negative response rate may indicate overuse of the query by the coding staff; a high positive response rate may indicate a pattern of incomplete documentation that needs further investigation.

Performing retrospective physician queries as part of a retrospective audit does not constitute a change in the Scope of Work; it is merely a necessary step that a coder/auditor might need to take in order to determine how a chart properly should have been coded.

3 Inpatient Audit Methodology

It is desirable to have an otherwise random sample of MS-DRGs within the targeted sample selected for review. If one MS-DRG is overly inclusive, replace it with another random chart.

(a) Develop Audit Selection Criteria: Determine what type of audit will be conducted and determine an appropriate focus for targeted audits.

(b) Request Supporting Documentation: Provide the list of charts to the medical records department for them to pull. The medical records department will either send them to the coder/auditor or the coder/auditor will retrieve the charts from the medical record department.

(c) Reconcile the Requested Sample to the Sample Received: The coder/auditor checks off the chart against the list of charts provided to the medical records department.

(d) Conduct Audit: The coder/auditor reviews the medical record documentation to determine appropriate assignment of the diagnostic and procedural codes. Patient sex, age, and disposition type for each chart must be verified for accuracy.

(e) Record Audit Findings: The coder/auditor will record the audit findings in NAVMED 6150/44, Inpatient Coding Audit Worksheet; this worksheet is available from Naval Forms Online at the following URL:

https://navalforms.daps.dla.mil/web/public/home

Discrepancies identified with patient sex, age, and disposition type must be recorded in the comment field of the worksheet.

(f) Record Coder/Auditor Comments: If there is any disagreement between submitted and audited codes, the coder/auditor will provide a detailed explanation of why the audited code was selected in comparison to the submitted code. Coder/Auditor explanation must cite the referenced coding source(s).

(g) Record Audit Statistics: The coder/auditor records the difference (+/-) between Audited RVU/RWP and Original RVU/RWP from CCE. The difference will be entered in the change field of the worksheet.

(h) Write Audit Report: The coder/auditor will write a report summarizing the purpose, methodology, findings, and recommendations of the audit.

(i) Feedback Meeting: The coder/auditor will prepare an audit report with an Executive Summary to list identified trends in documentation and error rates and recommendations for improvement. The Executive Summary shall be provided to the MTF designee(s) and shall include NAVMED 6150/48, Coding Audit Summary. NAVMED 6150/48 is available from Naval Forms Online at the following URL:

https://navalforms.daps.dla.mil/web/public/home

The audited records and audit sheets shall be retained by the MTF designee(s) for a period of two years. The coder/auditor will then meet with the MTF designee(s) (i.e., provider, coder, specialty leader) to review these audit findings and discuss corrections and opportunities for improvement. A plan of action will be required for any coder falling below 95% accuracy. If a plan of action is required, it will be developed at this meeting and distributed to the participants, including any follow-up audits to be performed. In the event the coder remains below 95%, the department head will be notified. Department head will develop a Plan of Action and Milestones document toward meeting coding compliance by relevant individuals.

(j) Plan of Action: The MTF designee(s) will ensure that the plan of action developed during feedback meetings is forwarded to the Navy Medicine Region Commander for assessment. Navy Medicine Region Commanders shall assist the MTFs in developing the action plan and should monitor MTF progress towards resolution.

3.1 MS-DRG Accuracy

The coder/auditor will recode the inpatient chart, group using CCE and compare the audit MS-DRG to the original MS-DRG. Since a chart can and must have one and only one principal diagnosis, an accuracy rate will be determined by dividing the number of *correct* principal diagnosis codes by the number of charts audited in the sample by the coder/auditor. For an individual inpatient medical record, the accuracy percentage will always be 100% or 0%.

Roll-up Example: Thirty charts were audited and there were two principal diagnosis errors. (Twenty-eight were correct.) Twenty-eight is divided by the 30 charts audited. 28 divided by 30 equals 93.3% accuracy.

This is a targeted audit element which is also a DQMC-required element.

3.1.1 Principal Diagnosis Accuracy

The coder/auditor will recode the inpatient chart and compare the audit principal diagnosis to the original principal diagnosis. Since a chart can and must have one and only one principal diagnosis, an accuracy rate will be determined by dividing the number of *correct* principal diagnosis codes by the number of charts audited in the sample by the coder/auditor.

Roll-up Example: Thirty charts were audited and there were two principal diagnosis errors. (Twenty-eight were correct.) Twenty-eight is divided by the 30 charts audited. 28 divided by 30 equals 93.3% accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

3.1.2 Major Complication and Co-Morbidity (MCC) Accuracy

The accurate capture--or failure to capture--MCCs needs to be tracked since the MCCs have the potential to change MS-DRGs. The coder/auditor will recode the inpatient chart and compare the coder/auditor's MCCs coded to the original MCCs coded. An accuracy rate will be determined by dividing the number of *correct* MCC codes by the sum total of codes contained in the union of the set of MCC codes reported by the original coder and the set of MCC codes reported by the coder/auditor.

Example: The original coding showed two MCCs (both deemed correct), while the coder/auditor determined that three additional MCCs should have been coded. Divide the number of correctly coded MCCs (2) by the combined total of codes reported by coder and the coder/auditor (2 + 3 = 5). 2 divided by 5 equals 40.0% accuracy.

Roll-up Example: Thirty charts were audited. Of the 75 MCCs reported, 70 were found to be correct. Seventy is divided by the combined total of 75 original MCC codes plus eight additional MCC codes that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

3.1.3 Complication and Co-Morbidity (CC) Accuracy

The accurate capture--or failure to capture--CCs needs to be tracked as they have the potential to change MS-DRGs. The coder/auditor will recode the inpatient chart and compare the coder/auditor's CCs coded to the original CCs coded. An accuracy rate will be determined by dividing the number of *correct* CC codes by the sum total of codes contained in the union of the set of CC codes reported by the original coder and the set of CC codes reported by the coder/auditor.

> *Example: The original coding showed two CCs (both deemed correct), while the coder/auditor determined that three additional MCCs should have been coded. Divide the number of correctly coded CCs (2) by the combined total of codes reported by coder and the coder/auditor (2 + 3 = 5). 2 divided by 5 equals 40.0% accuracy.*
>
> *Roll-up Example: Thirty charts were audited. Of the 75 CCs reported, 70 were found to be correct. Seventy is divided by the combined total of 75 original CC codes plus eight additional CC codes that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.4% accuracy.*

This is a unique metric which does not currently exist in the DQMC standard.

3.1.4 Present on Admission Indicator (POA) Accuracy

MS-DRGs require that *each diagnosis* have a corresponding POA indicator. The purpose of this indicator is to identify Hospital Acquired Conditions (HAC) that may be excluded from the MS-DRG calculation. The coder/auditor will review the record and determine the correct POA indicator for each diagnosis coded. The coder/auditor will compare the coder/auditor's POA indicators to the original POA indicators. Since each diagnosis can and must have one and only one POA indicator, an accuracy rate will be reported by dividing the number of *correct* POA indicators by the total number of diagnosis codes audited in the sample by the coder/auditor.

> *Roll-up Example: Thirty charts were audited. There were 126 diagnoses--and some POA indicators were assigned. Review showed that four of the POA indicators were incorrect and two were missing altogether. (120 POA indicators were correct.) Divide the number of correct POA indicators (120) by the total number of diagnosis codes audited in the sample by the coder/auditor. 120 divided by 126 equals 95.2% accuracy.*

This is a unique metric which does not currently exist in the DQMC standard.

3.1.5 Principal Procedure Accuracy

The coder/auditor will recode the inpatient chart and compare the coder/auditor's principal procedure code to the original principal procedure code. An accuracy rate will be reported by dividing the number of *correct* principal procedure codes by the sum total of codes contained in the union of the set of principal procedure codes reported by the original coder and the set of principal procedure codes reported by the coder/auditor.

> *Roll-up Example: Thirty charts were audited and there were two principal procedure errors. (Twenty-eight were correct.) Twenty-eight is divided by the 30 charts audited. 28 divided by 30 equals 93.3% accuracy.*

This is a unique metric which does not currently exist in the DQMC standard.

3.1.6 Relative Weighted Product (RWP) Changes

For TRICARE, inpatient workload is measured by the TRICARE Relative Weight Product (RWP). RWP is directly related to the MS-DRG assigned; RWP accuracy would be equal to the MS-DRG accuracy described above. The usefulness of measuring RWP changes comes from trending the monthly gain or loss over time. The coder/auditor will recode the chart, group using CCE, and compare the audit MS-DRG RWP to the original MS-DRG RWP. Coder/auditor will note a gain (+) or loss (-) for each MS-DRG change.

> *Example: Thirty charts were audited and there were two MS-DRG errors. The first MS-DRG RWP change gained +0.7654 while the second MS-DRG RWP change lost -0.0476 for a net gain of +0.7178 RWP.*

This is a unique metric which does not currently exist in the DQMC standard.

4 Outpatient Audit Methodology

It is desirable to have an otherwise random sample of charts within the targeted sample selected for review.

(a) Develop Audit Selection Criteria: Determine what type of audit will be conducted based on what item(s) are to be studied.

(b) Request Supporting Documentation: provide the list of charts to the medical records department for them to pull. The medical records department will either send them to the coder/auditor or the coder/auditor will retrieve the encounters/charts from the medical record department. Because outpatient documentation involves a hybrid of paper and electronic documentation, the audit can be done in AHLTA, the electronic record.

(c) Reconcile the Requested Sample to the Sample Received: The coder/auditor checks off the chart against the list of charts provided to the medical records department.

(d) Conduct Audit: The coder/auditor reviews the medical record documentation to determine appropriate assignment of the diagnostic and procedural codes. Patient sex, age, and disposition type for each chart must be verified for accuracy.

(e) Record Audit Findings: The coder/auditor will record the audit findings in NAVMED 6150/45, Outpatient Clinic Visit Coding Audit Worksheet; this worksheet is available from Naval Forms Online at the following URL:

https://navalforms.daps.dla.mil/web/public/home

Discrepancies identified with patient sex, age, and disposition type must be recorded in the comment field of the worksheet.

(f) Record Coder/auditor Comments: If there is any disagreement between submitted and audited codes, the coder/auditor will provide a detailed explanation of why the audited code was selected in comparison to the submitted code. Auditor explanation must cite the referenced coding source(s).

(g) Record Audit Statistics: The coder/auditor records the difference (+/-) between Audited RVU/RWP and Original RVU/RWP from CCE. The difference will be entered in the change field of the worksheet.

(h) Write Audit Report: The coder/auditor will write a report summarizing the purpose, methodology, findings, and recommendations of the audit.

(i) Feedback Meeting: The coder/auditor will prepare an audit report with an Executive Summary to list identified trends in documentation and error rates and recommendations for improvement. The Executive Summary shall be provided to the MTF designee(s) and shall include NAVMED 6150/50, Outpatient Coding Audit Summary. NAVMED 6150/50 is available from Naval Forms Online at the following URL:

https://navalforms.daps.dla.mil/web/public/home

The audited record and audit sheets shall be retained by the MTF designee(s) for a period of two years. The coder/auditor will then meet with the MTF designee(s) (i.e., provider, coder, specialty leader) to review these audit findings and discuss corrections and opportunities for improvement. A plan of action will be required for any coder falling below 95% or provider falling below 90% accuracy. If a plan of action is required, it will be developed at this meeting and distributed to the participants, including any follow up audits to be performed. In the event the coder remains below 95% or the provider remains below 90% accuracy, the department head will be notified. Department head will develop a Plan of Action and Milestones document toward meeting coding compliance by relevant individuals.

(j) Plan of Action: The MTF designee(s) will ensure that the plan of action developed during feedback meetings is forwarded to the Navy Medicine Region Commander for assessment.

4.1 Diagnosis Accuracy

The coder/auditor will recode the outpatient encounter and compare the audit diagnoses to the original diagnoses. An accuracy rate will be reported by dividing the number of original correct diagnoses by the sum total of diagnosis codes contained in the union of the set of diagnosis codes reported by the original coder and the set of diagnosis codes reported by the coder/auditor.

> *Example: An outpatient encounter was originally assigned four diagnoses codes. The coder/auditor determined that only three of the four diagnoses codes were appropriately addressed in the documentation and the fourth diagnosis code was therefore inappropriately assigned. Divide the number of correct diagnosis codes (3) by the combined total number of diagnosis codes that were found by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0% accuracy.*
>
> *Roll-up Example: There were 30 encounters audited. Twenty-six of these encounters had multiple diagnoses. There was a collective total of 66 originally-assigned diagnoses. The coder/auditor determined that 50 of these diagnoses codes were correct and also found 5 others that the coder should have reported by did not. Dividing the number of correct diagnoses codes (50) by the combined total number of diagnoses codes originally assigned plus the codes that were missed (66 + 5 = 71) yields 70.4% accuracy.*

This is a targeted audit element which is also a DQMC-required element.

4.2 *Current Procedural Terminology (CPT)* Accuracy

The coder/auditor will recode the outpatient encounter and compare the audit *CPT* codes to the original *CPT* codes. An accuracy rate will be reported by dividing the number of correct *CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor. "Correct" for the purposes of these audits means that both the primary *CPT* code is correct and all other non-primary *CPT* codes are correct (although the relative positions of these non-primary *CPT* codes is unimportant.

> *Example: There were three procedures (CPT) codes assigned by the coder and the coder/auditor determines that two of these were correct. The coder/auditor also identified one further CPT code that the coder should have captured but did not. Divide the number of correct CPT codes assigned (2) by the combined total of the number of CPT codes assigned by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (3 + 1 = 4). 3 divided by 4 equals 75.0% accuracy.*

Roll-up Example: There were 30 outpatient encounters audited with a collective total of 80 CPT codes assigned by the provider/coder. Of these 80 CPT codes, 10 were found to be incorrect by the coder/auditor with 70 being correct. The coder/auditor also identified six additional CPT codes that the coder should have captured but did not. Divide the total number of correct CPT codes (70) by the combined total number of CPT codes assigned by the initial provider/coder plus the number of CPT codes that the coder should have captured but did not (80 + 6 = 86). 70 divided by 86 yields 81.4% accuracy.

This is a targeted audit element which is also a DQMC-required element.

4.3 Evaluation and Management (E/M) Accuracy

The coder/auditor will recode the outpatient encounter and compare the audit E/M level to the original E/M level. An accuracy rate will be reported by dividing the number of correct E/M levels assigned by the coder by the by the sum total of E/M codes contained in the union of the set of E/M codes reported by the original coder and the set of E/M codes reported by the coder/auditor.

Example: The coder/auditor reviewed an encounter which had one E/M level assigned by the coder. This was found to be an incorrect code. Additionally, the coder/auditor identified a second E/M code that should have been reported but was not. Divide the number of correct E/M levels (0) by the combined total number of E/M codes that were missed (1 + 1 = 2). 0 divided by 2 yields 0.0% accuracy.

Roll-up Example: There were 30 outpatient encounters audited with a collective total of 32 E/M codes assigned by the provider/coder. Of these 32 E/M codes, 3 were found to be incorrect by the coder/auditor with 29 being correct. The coder/auditor also identified two further E/M codes that the coder should have captured but did not. Divide the total number of correct E/M codes (29) by the combined total number of E/M codes assigned by the initial coder plus the two that were missed by the coder (32 + 2 = 34). 29 divided by 34 yields 85.3% accuracy.

This is a targeted audit element which is also a DQMC-required element.

4.3.1 Modifier Accuracy

Often modifiers are necessary to fully explain the care provided. The coder/auditor will recode the outpatient encounter and assign modifiers as appropriate. An accuracy rate will be determined by dividing the number of *correct* modifiers by the sum total of modifiers contained in the union of the set of modifiers reported by the original coder and the set of modifiers reported by the coder/auditor.

Example: The original coding showed four modifiers assigned and three were deemed correct by the coder/auditor. Divide the number of correct modifiers (3) by the combined total of modifiers reported by the coder (4) plus the number of modifiers that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0% accuracy.

Roll-up Example: Thirty charts were audited. Of the seventy-five modifiers that were reported, seventy were found to be correct. Seventy is divided by the combined total of seventy-five original modifiers plus eight additional modifiers that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.

Modifiers are an important part of coding. It would be appropriate to measure not only that all necessary modifiers are captured and reported but that stray, inappropriate modifiers are not reported.

This is a unique metric which does not currently exist in the DQMC standard.

4.3.2 Units of Service Accuracy

The coder/auditor will recode the outpatient encounter and will assign Units of Service as appropriate. An accuracy rate will be determined by dividing the number of *correct* Units of Service by the sum total of Units of Service contained in the union of the set of Units of Service reported by the original coder and the set of Units of Service reported by the coder/auditor.

Example: The original coding showed six Units of Service assigned; while the audit showed seven Units of Service should have been reported. Dividing the number of correctly coded Units of Service (6) by the combined total of modifiers reported by coder and the coder/auditor (7 + 0 = 7). 6 divided by 7 equals 85.7% accuracy.

Roll-up Example: Thirty charts were audited. Of the seventy-five Units of Service that were reported, seventy were found to be correct. Seventy is divided by the combined total of seventy-five original Units of Service plus eight additional Units of Service that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

4.3.3 *CPT* Code "Linkage" Accuracy

Coders are required to "link" each *CPT* code assigned to a corresponding diagnosis code(s).

The coder/auditor will recode the outpatient encounter and will link the *CPT* codes to all appropriate International Classification of Diseases, Ninth Edition; Clinical Modification (ICD-9-CM) diagnosis codes. An accuracy rate will be determined by dividing the number of *correctly-linked CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor.

> *Example: The original coding showed 10 CPT codes assigned while an audit determined only 8 of the CPT codes to be correctly linked to all the appropriate ICD-9-CM diagnosis codes. Divide the number of correctly linked CPT codes (8) by the combined total of CPT codes reported by the coder and the coder/auditor (10 + 0 = 10). 8 divided by 10 equals 80.0% accuracy.*
>
> *Roll-up Example: Thirty charts were audited. Of the seventy-five CPT codes that were reported, seventy were found to be correctly linked to all appropriate ICD-9-CM codes. Seventy is divided by the combined total of seventy-five original CPT codes plus eight additional CPT codes that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.*

This is a unique metric which does not currently exist in the DQMC standard.

4.3.4 Relative Value Unit (RVU) Changes

Outpatient workload is measured by RVU. RVUs are directly related to the *CPT* and E/M codes. The coder/auditor will recode the outpatient service and compare the audit RVUs to the original RVUs. The coder/auditor will note a gain (+) or loss (-) for each encounter.

> *Example: Thirty rounds were audited and there were four CPT/E/M code changes. The first change resulted in a gain of +0.7654 RVU; the second resulted in a gain of +0.0476 RVU; the third change resulted in a gain of +0.2568 RVU; and the fourth change resulted in a loss of -0.4762 RVU-- for a net gain of +0.5936 RVU.*

This is a unique metric which does not currently exist in the DQMC standard.

4.4 E/M Calculation (1995) Worksheet

Use the Evaluation and Management Services Audit Scoresheet Tools as developed by the Marshfield Clinic for use with the CMS 1995 or 1997 *Documentation Guidelines for Evaluation and Management Services* (depending upon the Outpatient Coding Protocol Plan) as outlined in Section 2.6 (c) of this document.

E/M Worksheet (1995 Guidelines)

History: Requires 3 of 3 (HPI, ROS, and PFSH) levels be met							
Level		PF		EPF		Detailed	Comprehensive
HPI		Brief 1-3 Elements				Extended 4+ Elements	
		Location		Duration		Severity	Context
		Timing		Quality		Modifying Factors	Assoc. Signs & Sym
ROS		None		Pertinent (1)		Extended (2-9)	Complete (10+)
		Const		Eyes		Resp	GI
		Skin		ENT		CB	GU
		Musc		Neuro		Psych	Hem
		Lymph		Endo		Allergy	Immunology
PFSH		None		None		Pertinent 1-2 (New), 1 (Est)	Extended 3 (New), 2-3 (Est)
		Past		Family		Social	

Examination							
Level		PF (1)		EPF (2-7 limited)		Detailed (2-7 extended)	Comprehensive (8 or more)
Body Areas		Head		Neck		Back	Abdomen
		Chest		Groin		Genitalia	Buttocks
		RUE		LUE		RLE	LLE
Organ Systems		Cons		Eyes		Resp	GI
		Skin		ENT		CV	GU
		Musc		Neuro		Psych	Hem/Lymph/Immun

Medical Decision Making: 2 of 3 (A, B, and C) levels must be met or exceeded							
Level		Straight-forward		Low		Moderate	High
Table A		1 point		2 points		3 points	4+ points
Table B		0-1 point		2 points		3 points	4+ points
Table C		Minimal		Low		Moderate	High

4.5 E/M Worksheet (1997 Guidelines)

Use the Evaluation and Management Services Audit Scoresheet Tools as developed by the Marshfield Clinic for use with the CMS 1995 or 1997 *Documentation Guidelines for Evaluation and Management Services* (depending upon the Outpatient Coding Protocol Plan) as outlined in Section 2.6 (c) of this document.

E/M Worksheet (1997 Guidelines)

HISTORY

HPI: ①

Not documented by Physician

Timing	Assoc. S & S
Location	Context
Quality	Modifying Factors
Severity	3+ Chronic Conditions
Duration	**TOTAL HPI:**

ROS: ②

Constitutional (wt. loss, vitals)	Eyes	ENMT	
GI	Respiratory	Cardiovascular	
Integumentary w/skin, breast	GU	Musculo	Neuro
Psych	Allergy/Immuno	Lymphatic/Hemat	
Endocrine			

TOTAL ROS: _____

Statement: All remaining systems negative

PFSH: ③

Past (includes illness, surgical hx, injuries, etc.)

Family (includes hereditary conditions)

Social (Includes drinking, smoking, substance abuse)

Table A: History Matrix (All 3 satisfied)

HPI①	PF 1-3	EPF 1-3	Detailed 4+ elements or 3+ Chronic/ Inactive conditions	Comprehensive 4+ elements or 3+ Chronic/ inactive Conditions
ROS②	None	1 pertinent to problem	2-9	10+ or some with All others negative
PFSH ③	None	None	(1) Pertinent	*Complete 2-3 areas

*Complete PFSH 2 hx areas: a)Estab pts office (outpt) care, domiciliary care, home care, b)Emergency dept. c)Subseq nurs. Facility care

3 hx areas: a)New pts. Office (outpt) care, domiciliary care, home care, b)Consultations, c)Initial hospital care, d)Hospital Observation, e)Comprehensive nursing facility assmts.)

E/M Worksheet (Cont.)
1997 Guidelines

Content and Documentation Requirements	
Level of Exam	Perform and Document
Problem Focused	**One to five** elements identified by a bullet.
Exp. Prob. Focused	**At least six** elements identified by a bullet.
Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** OR **at least twelve** elements identified by a bullet **in two or more areas/systems**.
Comprehensive	**At least two** elements identified by a bullet **from each of the nine areas/systems**.

General Multi-System Exam

Constitutional
Vitals – 3
Appearance

Eyes
Conjunctivae/Lids
Pupils/Irises
Ophthalmoscopic

Ears/Nose/Mouth/Throat
External inspection (ears/nose)
Auditory canals/tympanic membranes
Hearing
Nasal mucosa/septum and turbinates
Lips/teeth/gums Oropharynx

Neck
Thyroid
Masses

Respiratory
Effort Percussion
Auscultation Palpation

Cardiovascular
Auscultation Palpation Carotid Arteries
Femoral Art. Pedal pulses Ext/edema/varicose

GI
Abd mass/tenderness Liver/Spleen Hernia Present
Anus/rectum/hemorrhoids/mass Stool Sample

Genitourinary: (Male)
Scrotal contents Penis Prostate

Genitourinary: (Female)
Ext. Genitalia/Vagina
Urethra Uterus Cervix
Bladder Adnexa

Lymphatic (must have at least 2): Neck Axillae Groin Other

Neurologic: Cranial DTRs Sensation

Psychiatric: Orientation Mood/Affect Judgment Memory

Skin: Inspection Palpation

Musculoskeletal: Gait/Station Nails/Digits
Joints, bones, and muscles of one or more areas.
Head/Neck Spine/Ribs/Pelvis
Right Upper Extremity Right Lower Extremity
Left Upper Extremity Left Lower Extremity
Exam includes:
Inspection/palpation noting any effusion, crepitation
Assessment of ROM Assessment of stability
Assessment of muscle strength and tone

Chest/Breasts:
Inspection of breasts (symmetry, discharge, nipples)
Palpation of breasts and axillae (masses, lumps, tenderness)

EXAM TOTAL: _____

E/M Worksheet (Cont.) 1997 Guidelines

Table A: Number of Diagnoses or Treatment Options			
Problems to Exam Physician	**Number X Points = Result**		
Self-limited or minor (stable, improved or worsening)		1	*Max = 2*
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned		3	*Max = 3*
New prob. (to examiner); add workup planned		4	
			TOTAL _____

Table B: Complexity of Data	
1 pt. = Diag. Tests ordered/Reviewed (Lab, X-ray, EKG) [1 pt. per test type]	
1 pt. = Test results discussed w/performing MD	
1 pt. = Obtain old records/history from outside source	
2 pts. = Review and Summarize old Medical Records	
2 pts. = Direct reading of image, tracing/specimen	
	TOTAL _____

Table C: Table of Risk			
Level of Risk	**Presenting Problem**	**Diag. Procedures Ordered**	**Management Options**
Minimal	*One self-limited or minor problem (e.g., cold, insect bite, tinea corporis)	*Lab tests – venipuncture *Chest X-ray *EKG/EEG *Urinalysis *KOH Prep	*Rest *Gargle *Elastic bandages *Superficial dressings
Low	*Two/more self-limited minor prob. *One stable chronic Illness *Acute uncomplicated illness or injury	*Physiologic tests not under stress (e.g., pulmonary funct.) *Non-cardio imaging w/ contrast (e.g., B/E) *Superficial needle/skin BX *Clinical lab tests = arterial punct.	*Over-the-counter drugs *Minor surgery/no risk factors *PT *OT *IV fluids w/o additive
Moderate	*One/more chronic illnesses w/mild progression-side effect TX *Two/more stable chronic illnesses *UnDX'd new problem w/uncertain prognosis *Acute illness w/systematic SX (e.g. pneumonia, colitis) *Acute uncomplicated injury	*Physiologic tests under stress *DX endoscopies w/o risk factor *Deep needle BX *Refer patient for consult *Cardio imaging studies w/contrast, w/o risk factors *Obtain body cavity fluid	*Minor surgery w/risk factor *Elective major surgery w/o risk factor *Prescription management *TX nuclear medicine *Closed FX treatment/dislocation w/o reduction *IV fluids w/additive(s)
High	*One/more chronic illness w/severe progression – side effect of TX *Acute/chronic illnesses/injuries threat to life *Abrupt neurologic change	*Cardio imaging studies w/contrast, w/risk factor *Cardiac electrophysiologic tests *Diag. endoscopies w/risk factor *Discography	*Elective major surgery w/risk factor *Emergency major surgery *Parenteral controlled substances *Drug TX w/intense monitor for toxicity *Decision not to resuscitate or to de-escalate care due to poor prognosis
			TOTAL _____

Medical Decision Making Matrix (2 of 3 Satisfied)				
MDM Type	**SF**	**LC**	**MC**	**HC**
Table A	0-1 Minimal	2 Limited	3 Multiple	4 Extensive
Table B	0-1 Minimal	2 Limited	3 Multiple	4 Extensive
Table C	*Minor, Self Limited Problem	*2+ Minor *1 chronic stable *1 acute	*2+ chronic w/1 severe *New prob? *1 acute w/system SX	*1+ chronic w/severe exacerb. *a/c threat to life *neuro

5 Ambulatory Procedure Visit (APV) Audit Methodology

It is desirable to have an otherwise random sample of charts within the targeted sample selected for review. If fewer than 30 APVs were performed in any month, then all APVs will be audited.

(a) Develop Audit Selection Criteria: Determine what type of audit will be conducted based on what item(s) are to be studied.

(b) Request Supporting Documentation: Provide the list of charts to the medical records department for them to pull. The medical records department will either send them to the coder/auditor or the coder/auditor will retrieve the charts from the medical record department.

(c) Reconcile the Requested Sample to the Sample Received: The coder/auditor checks off the chart against the list of charts provided to the medical records department.

(d) Conduct Audit: The coder/auditor reviews the medical record documentation to determine appropriate assignment of the diagnostic and procedural codes. Patient sex, age, and disposition type for each chart must be verified for accuracy.

(e) Record Audit Findings: The coder/auditor will record the audit findings in NAVMED 6150/46, APV Coding Audit Worksheet; this worksheet is available from Naval Forms Online at the following URL:

https://navalforms.daps.dla.mil/web/public/home

Discrepancies identified with patient sex, age, and disposition type must be recorded in the comment field of the worksheet.

(f) Record Coder/auditor Comments: If there is any disagreement between submitted and audited codes, the coder/auditor will provide a detailed explanation of why the audited code was selected in comparison to the submitted code. Auditor explanation must cite the referenced coding source(s).

(g) Record Audit Statistics: The coder/auditor records the difference (+/-) between Audited RVU/RWP and Original RVU/RWP from CCE. The difference will be entered in the change field of the worksheet.

(h) Write Audit Report: The coder/auditor will write a report summarizing the purpose, methodology, findings, and recommendations of the audit.

(i) Feedback Meeting: The coder/auditor will prepare an audit report with an Executive Summary to list identified trends in documentation and error rates and recommendations for improvement. The Executive Summary shall be provided to the MTF designee(s) and shall include NAVMED 6150/51, APV Coding Audit Summary. NAVMED 6150/51 is available from Naval Forms Online at the following URL:

https://navalforms.daps.dla.mil/web/public/home

The audited records and audit sheets shall be retained by the MTF designee(s) for a period of two years. The coder/auditor will then meet with the MTF designee(s) (i.e., provider, coder, specialty leader) to review these audit findings and discuss corrections and opportunities for improvement. A plan of action will be required for any coder falling below 95% or provider falling below 90% accuracy. If a plan of action is required, it will be developed at this meeting and distributed to the participants, including any follow up audits to be performed. In the event the coder remains below 95% or the provider remains below 90% accuracy, the department head will be notified. Department head will develop a Plan of Action and Milestones document toward meeting coding compliance by relevant individuals.

(j) Plan of Action: The MTF designee(s) will ensure that the plan of action developed during feedback meetings is forwarded to the Navy Medicine Region Commander for assessment.

5.1 Diagnosis Accuracy

The coder/auditor will recode the APV encounter and compare the audit diagnoses to the original diagnoses codes. An accuracy rate will be reported by dividing the number of original correct diagnoses by the sum total of diagnosis codes contained in the union of the set of diagnosis codes reported by the original coder and the set of diagnosis codes reported by the coder/auditor.

> *Example: An outpatient encounter was originally assigned four diagnoses codes. The coder/auditor determined that only three of the four diagnoses codes were appropriately addressed in the documentation and the fourth diagnosis code was therefore inappropriately assigned. Divide the number of correct diagnosis codes (3) by the combined total number of diagnosis codes that were found by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0% accuracy.*
>
> *Roll-up Example: There were 30 APV encounters audited. Twenty-six of these encounters had multiple diagnoses. There was a collective total of 66 originally-assigned diagnoses. The coder/auditor determined that 50 of these diagnoses codes were correct and also found 5 others that the coder should have reported by did not. Dividing the number of correct diagnoses codes (50) by the combined total number of diagnoses codes originally assigned plus the codes that were missed (66 + 5 = 71) yields 70.4% accuracy.*

This is a targeted audit element which is also a DQMC-required element.

5.2 *Current Procedural Terminology (CPT)* Accuracy

The coder/auditor will recode the APV encounter and compare the audit *CPT* codes to the original *CPT* codes. An accuracy rate will be reported by dividing the number of correct *CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor. "Correct" for the

purposes of these audits means that both the primary *CPT* code is correct and all other non-primary *CPT* codes are correct (although the relative positions of these non-primary *CPT* codes is unimportant.

> *Example: There were three procedures (CPT) codes assigned by the coder and the coder/auditor determines that two of these were correct. The coder/auditor also identified one further CPT code that the coder should have captured but did not. Divide the number of correct CPT codes assigned (2) by the combined total of the number of CPT codes assigned by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (3 + 1 = 4). 3 divided by 4 equals 75.0% accuracy.*
>
> *Roll-up Example: There were 30 APV encounters audited with a collective total of 80 CPT codes assigned by the provider/coder. Of these 80 CPT codes, 10 were found to be incorrect by the coder/auditor with 70 being correct. The coder/auditor also identified six additional CPT codes that the coder should have captured but did not. Divide the total number of correct CPT codes (70) by the combined total number of CPT codes assigned by the initial provider/coder plus the number of CPT codes that the coder should have captured but did not (80 + 6 = 86). 70 divided by 86 yields 81.4% accuracy.*

This is a targeted audit element which is also a DQMC-required element.

5.2.1 Modifier Accuracy

Often modifiers are necessary to fully explain the care provided. The coder/auditor will recode the outpatient encounter and assign modifiers as appropriate. An accuracy rate will be determined by dividing the number of *correct* modifiers by the sum total of modifiers contained in the union of the set of modifiers reported by the original coder and the set of modifiers reported by the coder/auditor.

> *Example: The original coding showed four modifiers assigned and three were deemed correct by the coder/auditor. Divide the number of correct modifiers (3) by the combined total of modifiers reported by the coder (4) plus the number of modifiers that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0% accuracy.*
>
> *Roll-up Example: Thirty charts were audited. Of the 75 modifiers that were reported, 70 were found to be correct. Seventy is divided by the combined total of 75 original modifiers plus eight additional modifiers that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.*

Modifiers are an important part of coding. It would be appropriate to measure not only that all necessary modifiers are captured and reported but that stray, inappropriate modifiers are not reported.

This is a unique metric which does not currently exist in the DQMC standard.

5.2.2 Units of Service Accuracy

The coder/auditor will recode the outpatient encounter and will assign Units of Service as appropriate. An accuracy rate will be determined by dividing the number of *correct* Units of Service by the sum total of Units of Service contained in the union of the set of Units of Service reported by the original coder and the set of Units of Service reported by the coder/auditor.

> *Example: The original coding showed six Units of Service assigned; while the audit showed seven Units of Service should have been reported. Dividing the number of correctly coded Units of Service (6) by the combined total of modifiers reported by coder and the coder/auditor (7 + 0 = 7). 6 divided by 7 equals 85.7% accuracy.*
>
> *Roll-up Example: Thirty charts were audited. Of the 75 Units of Service that were reported, 70 were found to be correct. Seventy is divided by the combined total of 75 original Units of Service plus eight additional Units of Service that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.*

This is a unique metric which does not currently exist in the DQMC standard.

5.2.3 *CPT* Code "Linkage" Accuracy

Coders are required to "link" each *CPT* code assigned to a corresponding diagnosis code(s).

The coder/auditor will recode the outpatient encounter and will link the *CPT* codes to all appropriate ICD-9-CM diagnosis codes. An accuracy rate will be determined by dividing the number of *correctly-linked CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor.

> *Example: The original coding showed 10 CPT codes assigned while an audit determined only 8 of the CPT codes to be correctly linked to all the appropriate ICD-9-CM diagnosis codes. Divide the number of correctly linked CPT codes (8) by the combined total of CPT codes reported by the coder and the coder/auditor (10 + 0 = 10). 8 divided by 10 equals 80.0% accuracy.*
>
> *Roll-up Example: Thirty charts were audited. Of the seventy-five CPT codes that were reported, seventy were found to be correctly linked to all appropriate ICD-9-CM codes. Seventy is divided by the combined total of seventy-five original CPT codes plus eight additional CPT codes that were*

found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

5.2.4 RVU Changes

Outpatient workload is measured by Relative Value Units (RVUs). RVUs are directly related to the *CPT* and E/M codes. The coder/auditor will recode the IPS Round and compare the audit RVUs to the original RVUs. The coder/auditor will note a gain (+) or loss (-) for each encounter.

Example: Thirty rounds were audited and there were four CPT/E/M code changes. The first change resulted in a gain of +0.7654 RVU; the second resulted in a gain of +0.0476 RVU; the third change resulted in a gain of +0.2568 RVU; and the fourth change resulted in a loss of -0.4762 RVU--for a net gain of +0.5936 RVU.

This is a unique metric which does not currently exist in the DQMC standard.

6 Inpatient Professional Services Audit Methodology

(a) To audit the attending physician's professional services, one professional provider's services for one calendar day of the attending physician's professional services during each audited hospitalization will be audited from the randomly selected sample. For hospitalizations which begin and terminate the same calendar day, that calendar day will be audited. For all other hospitalizations, the registration number will determine if services for the first or second calendar day will be audited. Odd registration numbers will be audited for the first day and even registration numbers will be audited for the second day. All attending professional services documented on the selected day will be audited for correct coding.

(b) The coder/auditor will either review the hard copy documentation (inpatient chart) or the electronic record (Essentris). If the coder/auditor is utilizing the hard copy, the coder/auditor will provide a list of charts to the medical records department for them to pull.

(c) Conduct Audit: The coder/auditor reviews the medical record documentation to determine appropriate assignment of the diagnostic and procedural codes. As with other types of charts, the patient sex, age, and disposition type for each chart must be verified for accuracy.

(d) Record Audit Findings: The coder/auditor will record the audit findings in NAVMED 6150/47, IPS RNDS Coding Audit Worksheet; this worksheet is available from Naval Forms Online at the following URL:

https://navalforms.daps.dla.mil/web/public/home

Discrepancies identified with patient sex, age, and disposition type must be recorded in the comment field of the worksheet.

(e) Record Coder/auditor Comments: If there is any disagreement between submitted and audited codes, the coder/auditor will provide a detailed explanation of why the audited code was selected in comparison to the submitted code. Auditor explanation must cite the referenced coding source(s).

(f) Record Audit Statistics: The coder/auditor records the difference (+/-) between Audited RVU/RWP and Original RVU/RWP from CCE. The difference will be entered in the change field of the worksheet.

(g) Write Audit Report: The coder/auditor will write a report summarizing the purpose, methodology, findings, and recommendations of the audit.

(h) Feedback Meeting: The coder/auditor will prepare an audit report with an Executive Summary to list identified trends in documentation and error rates and recommendations for improvement. The Executive Summary shall be provided to the MTF designee(s) and shall include NAVMED 6150/49, IPS RNDS Coding Audit Summary. NAVMED 6150/49 is available from Naval Forms Online at the following URL:

https://navalforms.daps.dla.mil/web/public/home

The audited records and audit sheets shall be retained by the MTF designee(s) for a period of two years. The coder/auditor will then meet with the MTF designee(s) (i.e., provider, coder, specialty leader) to review these audit findings and discuss corrections and opportunities for improvement. A plan of action will be required for any coder falling below 95% accuracy. If a plan of action is required, it will be developed at this meeting and distributed to the participants, including any follow-up audits to be performed. In the event the coder remains below 95% accuracy, the department head will be notified. Department head will develop a Plan of Action and Milestones document toward meeting coding compliance by relevant individuals.

(i) Plan of Action: The MTF designee(s) will ensure that the plan of action developed during feedback meetings is forwarded to the Navy Medicine Region Commander for assessment.

(j) Follow-up Report: The MTF designee(s) will provide a report of actions and results of the plan of action to the MTF Commander and the Navy Medicine Region Commander for forward reporting to BUMED.

6.1 Diagnosis Accuracy

The coder/auditor will recode the IPS rounds and compare the audit-obtained diagnoses to the original diagnoses. An accuracy rate will be reported by dividing the number of original correct diagnoses by the total number of encounters audited.

> *Example: An inpatient round was originally assigned four diagnoses codes. The coder/auditor determined that only three of the four diagnoses codes were appropriately addressed in the documentation and the fourth diagnosis code was therefore inappropriately assigned. Divide the number of correct diagnosis codes (3) by the combined total number of*

diagnosis codes that were found by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0% accuracy.

Roll-up Example: There were 30 inpatient rounds audited. Twenty-six of these encounters had multiple diagnoses. There was a collective total of 66 originally-assigned diagnoses. The coder/auditor determined that 50 of these diagnoses codes were correct and also found 5 others that the coder should have reported by did not. Dividing the number of correct diagnoses codes (50) by the combined total number of diagnoses codes originally assigned plus the codes that were missed (66 + 5 = 71) yields 70.4% accuracy.

This is a targeted audit element which is also a DQMC-required element.

6.2 *Current Procedural Terminology (CPT)* Accuracy

The coder/auditor will recode the IPS rounds and compare the audit *CPT* codes to the original *CPT* codes. An accuracy rate will be reported by dividing the number of correct *CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor. "Correct" for the purposes of these audits means that both the primary *CPT* code is correct and all other non-primary *CPT* codes are correct (although the relative positions of these non-primary *CPT* codes is unimportant.

Example: There were three procedures (CPT) codes assigned by the coder and the coder/auditor determines that two of these were correct. The coder/auditor also identified one further CPT code that the coder should have captured but did not. Divide the number of correct CPT codes assigned (2) by the combined total of the number of CPT codes assigned by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (3 + 1 = 4). 3 divided by 4 equals 75.0% accuracy.

Roll-up Example: There were 30 encounters audited with a collective total of 80 CPT codes assigned by the provider/coder. Of these 80 CPT codes, 10 were found to be incorrect by the coder/auditor with 70 being correct. The coder/auditor also identified six further CPT codes that the coder should have captured but did not. Divide the total number of correct CPT codes (70) by the combined total number of CPT codes assigned by the

initial provider/coder plus the number of CPT codes that the coder should have captured but did not (80 + 6 = 86). 70 divided by 86 yields 81.4% accuracy.

This is a targeted audit element which is also a DQMC-required element.

6.3 Evaluation and Management (E/M) Accuracy

The coder/auditor will recode the IPS rounds and compare the audit E/M level to the original E/M level. An accuracy rate will be reported by dividing the number of correct E/M levels assigned by the coder by the sum total of E/M codes contained in the union of the set of E/M codes reported by the original coder and the set of E/M codes reported by the coder/auditor.

> *Example: The coder/auditor reviewed an inpatient round which had one E/M level assigned by the coder. This was found to be an incorrect code. Additionally, the coder/auditor identified a second E/M code that should have been reported but was not. Divide the number of correct E/M levels (0) by the combined total number of E/M codes that were missed (1 + 1 = 2). 0 divided by 2 yields 0.0% accuracy.*
>
> *Roll-up Example: There were 30 inpatient rounds audited with a collective total of 32 E/M codes assigned by the provider/coder. Of these 32 E/M codes, 3 were found to be incorrect by the coder/auditor with 29 being correct. The coder/auditor also identified two further CPT codes that the coder should have captured but did not. Divide the total number of correct E/M codes (29) by the combined total number of E/M codes assigned by the initial coder plus the two that were missed by the coder (32 + 2 = 34). 29 divided by 34 yields 85.3% accuracy.*

This is a targeted audit element which is also a DQMC-required element.

6.3.1 Modifier Accuracy

Often modifiers are necessary to fully explain the care provided. The coder/auditor will recode the outpatient encounter and assign modifiers as appropriate. An accuracy rate will be determined by dividing the number of *correct* modifiers by the sum total of modifiers contained in the union of the set of modifiers reported by the original coder and the set of modifiers reported by the coder/auditor.

> *Example: The original coding showed four modifiers assigned and three were deemed correct by the coder/auditor. Divide the number of correct modifiers (3) by the combined total of modifiers reported by the coder (4) plus the number of modifiers that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0% accuracy.*
>
> *Roll-up Example: Thirty charts were audited. Of the 75 modifiers that were reported, 70 were found to be correct. Seventy is divided by the combined total of 75 original modifiers plus eight additional modifiers that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.*

Modifiers are an important part of coding. It would be appropriate to measure not only that all necessary modifiers are captured and reported but that stray, inappropriate modifiers are not reported.

This is a unique metric which does not currently exist in the DQMC standard.

6.3.2 Units of Service Accuracy

The coder/auditor will recode the outpatient encounter and will assign Units of Service as appropriate. An accuracy rate will be determined by dividing the number of *correct* Units of Service by the sum total of Units of Service contained in the union of the set of Units of Service reported by the original coder and the set of Units of Service reported by the coder/auditor.

> *Example: The original coding showed six Units of Service assigned; while the audit showed seven Units of Service should have been reported. Dividing the number of correctly coded Units of Service (6) by the combined total of modifiers reported by coder and the coder/auditor (7 + 0 = 7). 6 divided by 7 equals 85.7% accuracy.*
>
> *Roll-up Example: Thirty charts were audited. Of the 75 Units of Service that were reported, 70 were found to be correct. Seventy is divided by the combined total of 75 original Units of Service plus eight additional Units of Service that were found by the coder/auditor (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.*

This is a unique metric which does not currently exist in the DQMC standard.

6.3.3 *CPT* Code "Linkage" Accuracy

Coders are required to "link" each *CPT* code assigned to a corresponding diagnosis code(s).

The coder/auditor will recode the outpatient encounter and will link the *CPT* codes to all appropriate ICD-9-CM diagnosis codes. An accuracy rate will be determined by dividing the number of *correctly-linked CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor.

> *Example: The original coding showed 10 CPT codes assigned while an audit determined only eight (8) of the CPT codes to be correctly linked to all the appropriate ICD-9-CM diagnosis codes. Divide the number of correctly linked CPT codes (8) by the combined total of CPT codes reported by the coder and the coder/auditor (10 + 0 = 10). 8 divided by 10 equals 80.0% accuracy.*
>
> *Roll-up Example: Thirty charts were audited. Of the 75 CPT codes that were reported, 70 were found to be correctly linked to all appropriate ICD-9-CM codes. Seventy is divided by the combined total of 75 original CPT codes plus eight additional CPT codes that were found by the*

coder/auditor but which were missed by the original coder (75 + 8 = 83). 70 divided by 83 equals 0.8433—84.3% accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

6.3.4 Relative Value Unit (RVU) Changes

Outpatient workload is measured by RVUs. RVUs are directly related to the *CPT* and E/M codes. The coder/auditor will recode the IPS Round and compare the audit RVUs to the original RVUs. The coder/auditor will note a gain (+) or loss (-) for each encounter.

Example: Thirty rounds were audited and there were four CPT/E/M code changes. The first change resulted in a gain of +0.7654 RVU; the second resulted in a gain of +0.0476 RVU; the third change resulted in a gain of +0.2568 RVU; and the fourth change resulted in a loss of -0.4762 RVU--for a net gain of +0.5936 RVU.

This is a unique metric which does not currently exist in the DQMC standard.

6.3.5 Rounds Applied to the Correct Service (*A MEPRS* Code)

A Round is coded for the attending physician's services rendered during each 24-hour period (midnight to midnight). Coders review all inpatient documentation for that 24-hour period and determine the attending physician and service (*A MEPRS* Code). The coder is then responsible for validating the service in Ambulatory Data Model (ADM) for that round. The accuracy of service designation is measured by dividing the number of rounds with the correct service by the total number of rounds audited. This is a File and Table Build issue. An inpatient professional services Standard Ambulatory Data Record (SADR) is generated automatically via Composite Health Care System (CHCS) for an admission. The coder/auditor will need MTF Information Technology Department support to correct any identified errors.

Roll-up Example: Thirty charts were audited and there were three that had the round applied to the incorrect MEPRS code. (Twenty-seven were correct.) Twenty-seven is divided by the combined total of 30 original rounds plus zero additional rounds that were found by the coder/auditor but which were missed by the original coder (30 + 0 = 30). 27 divided by 30 equals 90.0% accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

6.3.6 Rounds Applied to the Correct Attending Physician

A Round is coded for the attending physician's services rendered during each 24-hour period (midnight to midnight). Coders review all inpatient documentation for that 24-hour period and determine the attending physician. The coder is then responsible for validating the attending physician in ADM for that round. The accuracy of the attending physician designation is measured by dividing the number of rounds with the correct attending by the total number of rounds audited. This is a File and Table Build issue. An *A SADR* is generated automatically via

CHCS for an admission. The coder/auditor will need MTF Information Technology Department support to correct any identified errors.

> *Roll-up Example: Thirty charts were reviewed by the coder/auditor and there were three that had the round applied to the incorrect attending physician. (Twenty-seven were correct.) Twenty-seven is divided by the combined total of 30 original rounds plus zero additional rounds that were found by the coder/auditor but which were missed by the original coder (30 + 0 = 30). 27 divided by 30 equals 90.0% accuracy.*

This is a unique metric which does not currently exist in the DQMC standard.

7 Error Reason Codes Definitions

	Inpatient Institutional - Diagnosis Coding Reason Code List
D1	A diagnosis reported in positions 2 through 15 should have been listed as the principal diagnosis; the audited principal diagnosis changed the MS-DRG.
D2	A diagnosis reported in positions 2 through 15 should have been listed as the principal diagnosis; the audited principal diagnosis did not change the MS-DRG.
D3	None of the diagnoses reported were the correct principal diagnosis. (Excludes specificity errors which should be reported with codes D6-D8.) The audited principal diagnosis changed the MS-DRG.
D4	None of the diagnoses reported were the correct principal diagnosis. (Excludes specificity errors which should be reported with codes D6-D8.) The audited principal diagnosis did not change the MS-DRG.
D5	A diagnosis reported in any one of positions 2 through 15 cannot be substantiated in the supporting documentation.
D6	A diagnosis code with at least four digits matches all reported numbers within the code except the fourth digit.
D7	A diagnosis code with at least five digits matches all reported numbers within the code except the fifth digit.
D8	A diagnosis code with an extender digit matches all reported numbers within the code except the extender digit.
D9	A documented MCC was not coded, which causes the DRG to change.
D10	A documented MCC was not coded, which does not cause a change in the MS-DRG.
D11	Based upon the supporting documentation, the MCC should not have been coded. Removing the MCC changes the MS-DRG.
D12	Based upon the supporting documentation, the MCC should not have been coded. Removing the MCC does not change the MS-DRG.
D13	Based upon the supporting documentation, a complication/co-morbidity should have been assigned and will result in a change to the MS-DRG assignment.
D14	Based upon the supporting documentation, a complication/co-morbidity should have been assigned and will not result in a change to the MS-DRG assignment.
D15	Based upon the supporting documentation, a complication/co-morbidity code should not have been assigned and will change the MS-DRG assignment.
D16	Based upon the supporting documentation, a complication/co-morbidity code should not have been assigned and will not result in a change to the MS-DRG assignment.
D17	Based upon the supporting documentation, a diagnosis/diagnoses, which is/are not classified as a complication or co-morbidity, should have been assigned in the third to ninth position.
	Inpatient Institutional – POA Reason Code List
D18	Present on Admission indicator was left blank, and the audited POA changed the MS-DRG.
D19	Present on Admission indicator was left blank, and the audited POA did not change the MS-DRG.
D20	The POA was changed; the audited POA indicator changed the MS-DRG.
D21	The POA was changed; the audited POA indicator did not change the MS-DRG.
D22	A different disposition code should have been assigned; the audited disposition code changed the MS-DRG.
D23	A different disposition code should have been assigned; the audited disposition code did not change the MS-DRG.
	Inpatient Reason Codes for Querying
Q1	Query for principal diagnosis may impact MS-DRG.
Q2	Query for medical MCC may impact MS-DRG.
Q3	Query for medical CC may impact MS-DRG.
Q4	Query for surgical MCC may impact MS-DRG.

Q5	Query for surgical CC may impact MS-DRG.
Q6	Query for procedure code added query changes MS-DRG.
Q7	Query for diagnosis that does not impact MS-DRG.
	Inpatient Facility - Procedure Coding Reason Code List
I1	Principal procedure—incorrect sequencing; secondary procedure is principal procedure, affecting MS-DRG.
I2	Principal procedure—incorrect sequencing; secondary procedure is principal procedure, not affecting MS-DRG.
I3	Principal procedure—wrong code assigned; secondary procedures are not principal either, affecting MS-DRG.
I4	Principal procedure—wrong code assigned; secondary procedures are not principal either, not affecting MS-DRG.
I5	Documentation does not support coded secondary procedure, affecting MS-DRG.
I6	Documentation does not support coded secondary procedure, not affecting MS-DRG.
I7	Procedure not coded to appropriate level of specificity, affecting MS-DRG.
I8	Procedure not coded to appropriate level of specificity, not affecting MS-DRG.
I9	Failure to code documented procedure, affecting MS-DRG.
I10	Failure to code documented procedure, not affecting MS-DRG.
	APV / Outpatient/Inpatient Professional – E/M Coding Reason Code List
E1	The category of E/M code audited was not the same category of E/M code submitted. (New vs. Est., Consult vs. New, Inpt. Admit vs. Subsq. Day, Critical Care vs. Subsq. Day)
E2	The E/M code audited was 1 level below the reported E/M code.
E3	The E/M code audited was 2 levels below the reported E/M code.
E4	The E/M code audited was 3 levels below the reported E/M code.
E5	The E/M code audited was 4 levels below the reported E/M code.
E6	The E/M code audited was 1 level above the reported E/M code.
E7	The E/M code audited was 2 levels above the reported E/M code.
E8	The E/M code audited was 3 levels above the reported E/M code.
E9	The E/M code audited was 4 levels above the reported E/M code.
E10	Based upon the supporting documentation, an E/M code should not have been reported.
E11	Based upon the supporting documentation, an additional E/M code should have been reported.
	APV / Outpatient/Inpatient Professional - Diagnosis Coding Reason Code List
V1	A diagnosis reported in positions 2 through 15 should have been listed in the first diagnosis position.
V2	None of the diagnoses reported were the correct first-listed diagnosis. (Excludes specificity errors which should be reported with codes D6-D8.)
V3	A diagnosis reported in any one of positions 2 through 15 cannot be substantiated in the supporting documentation.
V4	A diagnosis code with at least four digits matches all reported numbers within the code except the fourth digit.
V5	A diagnosis code with at least five digits matches all reported numbers within the code except the fifth digit.
V6	A diagnosis code with an extender digit matches all reported numbers within the code except the extender digit.
V7	Based upon the supporting documentation, a diagnoses/diagnoses, which is/are not classified as a complication or co-morbidity, should have been assigned in the third to ninth positions.
V8	The diagnosis linked for this procedure (*CPT*/HCPCS) code was appropriate for another procedure (*CPT*/HCPCS) listed on the encounter, but not for this procedure (*CPT*/HCPCS) code.
	APV / Outpatient/Inpatient Professional - Modifiers Reason Code List
M1	A modifier was not reported for an E/M or *CPT*/HCPCS procedure; however, the supporting documentation and/or coding rules indicate that a modifier should be assigned.
M2	Based upon the supporting documentation, the modifier reported for an E/M or *CPT*/HCPCS procedure should be replaced by a different modifier.

M3	Based upon the supporting documentation, the modifier reported for an E/M or *CPT*/HCPCS procedure should not have been assigned.
M4	Based upon the supporting documentation, the modifiers reported for a procedure were incorrectly sequenced.
	APV / Outpatient/Inpatient Professional - Quantity Reason Code List
U1	Based upon the supporting documentation, the number listed in the units of service field should have been higher than the number reported.
U2	Based upon the supporting documentation, the number listed in the units of service field should have been lower than the number reported.
	APV / Outpatient/Inpatient Professional - Procedure Reason Code List
P1	A procedure code reported matches all numbers except the fifth digit.
P2	The procedure code reported should have been reported with a different *CPT* code.
P3	A procedure code reported should not have been reported because it is included, by definition of the procedures, within one other procedure reported on the same encounter.
P4	A procedure code was not reported in ascending RVU value order (highest value to lowest value).
P5	Based upon the supporting documentation, a procedure should not have been reported.
P6	Based upon the supporting documentation, a procedure should have been reported.
P7	A *CPT* code should have been reported versus a HCPCS code (Level II).
P8	A HCPCS code should have been reported versus a *CPT* code.
	APV / Outpatient/Inpatient Professional - Query
C1	Query for documentation that may affect coding.

8 Roles and Responsibilities

8.1 BUMED

(1) BUMED (M3/5 HCS3) Health Information Management is responsible for representing Navy at the Unified Biostatistical Utility (UBU) which, in turn, develops polices concerning inpatient and outpatient coding standard business practices, processes, and reporting requirements.

(2) BUMED (M3/5 HCS3) develops annual performance metrics, reporting requirements, and a tracking mechanism to monitor and ensure MTF compliance with coding and auditing of the closed medical record system.

(3) BUMED (M3/5 HCS3) analyzes data and develops written Navy policies concerning inpatient and outpatient coding standard business "best practices," processes, and reporting requirements, and promulgates these policies on a timely basis.

(4) BUMED (M3/5 HCS3) develops policies for Coding Audit Guidelines and works with DQMC manager to ensure compliance with Coding Audit Guidelines and determines oversight activities that are required for successful execution of Coding Audits.

8.2 Navy Medicine Regions

Commanders, Navy Medicine Region are responsible for assisting MTFs within their respective area of responsibility (AOR) in implementation of the policies and procedures defined in these Coding Audit Requirements and Guidelines. Navy Medicine Region Commanders will ensure correct and timely reporting, and will conduct external/shadow audits when necessary.

8.3 MTF Responsibilities

(a) The MTF commanding officer has the ultimate responsibility to ensure that all clinical documentation, clinical coding, and administrative procedures surrounding patient encounters are conducted following the requirements of these Coding Audit Requirements and Guidelines, applicable State and Federal laws, and The Joint Commission—formerly the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) standards. MTFs and MTF designee(s) will generate Follow-Up Reports as outlined in Chapter 6, and will ensure training programs are in place to correct noted deficiencies—including (but not limited to): individual and group education, feedback and query processes, and ensuring bilateral communication between providers and coders.

(b) The MTF commanding officer will ensure that a process is in place to correct retrospectively any specific coding errors that are identified during the course of the audit.

(c) The PAD is responsible to the commanding officer for ensuring compliance with these

guidelines and has functional oversight of the administrative coding process supporting both inpatient admissions and outpatient encounters.

(d) The Medical Records Administrator (MRA) reports to the PAD or appropriate designee. The MRA is responsible for oversight of the inpatient and outpatient coding staff, and coding processes and practices—including audits. The MRA is further responsible for ensuring that clinical documentation in the patient record supports and justifies the coding assigned for the episode of care. Deficiencies must have corrective action when identified.

9 Forms and Reports

9.1 Forms

The following NAVMED forms are available electronically from Naval Forms Online at https://navalforms.daps.dla.mil/web/public/home:

(a) NAVMED 6150/44 (01-2010), Inpatient Coding Audit Worksheet
(b) NAVMED 6150/45 (01-2010), Outpatient Clinic Visit Coding Audit Worksheet
(c) NAVMED 6150/46 (01-2010), APV Coding Audit Worksheet
(d) NAVMED 6150/47 (01-2010), IPS RNDS Coding Audit Worksheet
(e) NAVMED 6150/48 (01-2010), Inpatient Coding Audit Summary
(f) NAVMED 6150/49 (01-2010), IPS RNDS Coding Audit Summary
(g) NAVMED 6150/50 (01-2010), Outpatient Coding Audit Summary
(h) NAVMED 6150/51 (01-2010), APV Coding Audit Summary

9.2 Reports

The reports required by this guideline are assigned report control symbol NAVMED 6150-2. This reporting requirement is approved by Chief, BUMED for 3 years from the date of NAVMED POLICY 10-001, Coding Program Standard Audit Guidelines.

Appendix

ABBREVIATIONS, ACRONYMS and DEFINITIONS

ADM	Ambulatory Data Module
AHIMA	American Health Information Management Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AOR	Area of Responsibility
APV	Ambulatory Procedure Visit
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BUMED	Bureau of Medicine and Surgery
CC	Complication and Co-Morbidity
CCE	Coding Compliance Editor
CCS	Certified Coding Specialist
CCS-P	Certified Coding Specialist – Professional
CHCS	Composite Health Care System
CMS	Centers for Medicare and Medicaid Services
COR	Contracting Officer's Representative
CPC	Certified Professional Coder
CPC-H	Certified Professional Coder - Hospital
CPT	Current Procedural Terminology
DoD	Department of Defense
DoDI	Department of Defense Instruction
DQMC	Data Quality Management Control
EKG	Electrocardiogram

E/M	Evaluation and Management
H&P	History and Physical
HAC	Hospital Acquired Condition
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
IPS	Inpatient Professional Services
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MCC	Major Complication and Co-Morbidity
MEPRS	Medical Expense and Performance Reporting System
MHS	Military Health System
MS-DRG	Medicare Severity – Diagnosis Related Groups
MTF	Medical Treatment Facility
MRA	Medical Records Administrator
MRI	Magnetic Resonance Imaging
ORYX	ORYX is The Joint Commission's performance measurement and improvement initiative first implemented in 1997
PAD	Patient Administration Department
POA	Present on Admission
PPS	Prospective Payment System
RHIA	Registered Health Information Administrator
RHIT	Registered Health Information Technician
RNDS	Rounds (attending physician visits to hospitalized inpatients)

RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
UBU	Unified Biostatistical Utility